

FILED JUN 9 1947

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **2339**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. **JACKSON**
(b) City or town. **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **GENERAL HOSPITAL NO. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **14 DAYS** (Specify whether years, months or days)
In this community **40 YRS.**

2. USUAL RESIDENCE OF DECEASED:

(a) State. **MISSOURI** (b) County. **JACKSON 48**
(c) City or town. **KANSAS CITY 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **1016 GARFIELD 8**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **ALLENE ROUNTREE**

3. (b) If veteran, name war. **no** 3. (c) Social Security No. **No**

4. Sex **FEMALE 3** 5. Color or race. **NEGRO** 6. (a) Single, widowed, married, divorced. **MARRIED**

6. (b) Name of husband or wife. **PETER C. ROUNTREE** 6. (c) Age of husband or wife if alive. **63** years

7. Birth date of deceased. **APRIL 3rd, 1884** (Month) (Day) (Year)

8. AGE: Years **63** Months **01** Days **2329** If less than one day hr. min.

9. Birthplace. **KEYTESVILLE MISSOURI** (City, town, or county) (State or foreign country)

10. Usual occupation. **HOUSEWIFE**

11. Industry or business.

MOTHER FATHER { 12. Name. **THOMAS AKERS**
13. Birthplace. **UNKNOWN** (City, town, or county) (State or foreign country)
14. Maiden name. **MARY SHAMROCK**
15. Birthplace. **VIRGINIA** (City, town, or county) (State or foreign country)

16. (a) Informant. **PETER C. ROUNTREE (HUSBAND)**

(b) Address. **1016 GARFIELD**

17. (a) **Burial** (b) Date thereof. **May 28 1947** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. **Lincoln Adkins B. Hos.**

18. (a) Signature of funeral director. **Adkins B. Hos.**

(b) Address. **2000 E. 12th K.C. Mo.**

19. (a) **5-28-47** (b) **Geraldine Holmes** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **23,** year **1947** hour **5:** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **MAY 9,** 19**47** to **MAY 23,** 19**47**; that I last saw h. **ER** alive on **MAY 23,** 19**47**; and that death occurred on the date and hour stated above.

Immediate cause of death. **FAR ADVANCED CARCINO-MA OF CERVIX AND UTERUS WITH METASTASIS**

Due to.....

Due to.....

Other conditions. **SENILITY** (Include pregnancy within 3 months of death)

Major findings: Of operations..... **48** Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work..... (Specify type of place) (Specify type of means of injury)

Signature..... (M. D. or other) **M. D.** Address. **GENERAL HOSPITAL NO. 2** Date signed **5/24/47**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed A. T. Moore
Licensed Embalmer No. 948
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.